Michigan House of Representatives: Committee on Tort Reform
Revisiting the 1994 Medical Malpractice Legislation
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The Michigan Legislature has a responsibility to re-examine the medical malpractice legislation, now over a decade old, to determine if it is achieving its intended goal, and whether aspects should be changed to make it fair and effective.

In 1994 the Michigan Legislature passed extensive regulations governing medical malpractice claims. Traditionally, this law was established one case at a time through court decisions; also know as the common law. This court created method of establishing the law, while slow, had the advantage that when the law was unfair, simply did not work, or did not achieve its intended result, it could be corrected with a subsequent decision. On the other hand, while statutory regulation may be drafted with the best intentions and efforts, to remedy those sections that do not work as intended, requires a far greater effort. Nevertheless, if the legislature assumed the responsibility to codify the law, at the same time they assumed the responsibility to modify it when needed.

Time puts all well intended plans in perspective. This is extensive legislation, which had no precedent as a guide. This is legislation that has many sections that interact with one another. With no prior experience, it would be difficult, if not impossible, to foresee how all the sections would work together. As one of ATRA's spokesman's, Philip K. Howard, points out in his book, *The Death of Common Sense*, "The more precise the rule, the less sensible the law seems to be." [1]

The 1994 legislation is extensive and precise, and as we now know, some aspects are not sensible. Those sections of the legislation, which, due to technical deficiencies, deprive Michigan citizens of the protections of the law for highly meritorious claims, and which do not further the original intent of the legislation, should be corrected.

NOTICE OF INTENT TO FILE A CLAIM

Two parts of the 1994 malpractice legislation, while in part achieving their intended result, have, at the same time come to consume undue time and expenses of the parties and courts, have resulted in the unjust dismissal of meritorious claims, and the unnecessary limitations of those claims. These problems are due to purely procedural consequences of the interactions of the various statute sections, and the langauge of the statutes being given unreasonable and unintended meanings. The AOM (affidavit of merit) and the NOI (notice of intent to file a claim) sections, MCL 600.2912d and MCL 600.2912b, respectively, should be amended to enable the parties to pursue meritorious claims, to have their cases decided on their merits, and to eliminate the dismissal of these claims on purely procedural hurdles that in no way further the original intent of the legislation.

[1] Philip K. Howard, The Death of Common Sense (New York: Random House, 1994) p 15.

The NOI (notice of intent to file a claim) is required to be filed in all cases alleging medical malpractice before a formal action can be filed.

> [A] person shall not commence an action alleging medical malpractice against a health professional or health facility unless the person has given the health professional or health facility written notice under this section not less than 182 days before the action is commenced.[2]

Based on what the health care providers have elected to put in the medical records and what can be surmised from consulting with experts, the plaintiff is required to set forth what was done improperly, by whom, and state how that caused the injury. The statute requires the plaintiff to then wait 182 days before suit can be filed.[3] There is no ability to formally investigate or discover additional facts since the case has not been filed and the discovery provisions of the Michigan Rules of Civil Procedure are not yet available to the plaintiff.

> The notice given to a health professional or health facility under this section shall contain a statement of at least all of the following:
> (a) The factual basis for the claim.
> (b) The applicable standard of practice or care alleged by the claimant.
> (c) The manner in which it is claimed that the applicable standard of practice or care was breached by the health professional or health facility.
> (d) The alleged action that should have been taken to achieve compliance with the alleged standard of practice or care.
> (e) The manner in which it is alleged the breach of the standard of practice or care was the proximate cause of the injury claimed in the notice.
> (f) The names of all health professionals and health facilities the claimant is notifying under this section in relation to the claim.[4]

The intent of this provision was to provide an opportunity to resolve claims before expensive and time consuming litigation.[5]

Because all medical malpractice claims must be filed within two years from the date of negligence,[6] this statutory waiting period could potentially cause the statute of limitations to expire while the plaintiff waits for the 182 day waiting period to expire. To avoid this inequity, the legislature provided that if the NOI were sent within 182 days of the statute of limitations, the sending of the NOI tolls the statute of limitations, allowing the same period to file the complaint as existed at the time the NOI was sent.

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[2] MCL 600.2912b(1)

[3] There are exceptions where the time could be shortened, and at the discretion of the defendant, but the vast majority of claims will wait the 6 months before filing.

[4] MCL 600.2912b(4)

[5] The purpose of the notice requirement is to promote settlement without the need for formal litigation and reduce the cost of medical malpractice litigation while still providing compensation for meritorious medical malpractice claims that might otherwise be precluded from recovery because of litigation costs. Neal v Oakwood Hosp Corp, 226 Mich App 701,705; 575 NW2d 68 (1997).

[6] MCL 5805(6). The two years is presently calculated from the date of the negligent act, or at the time of the act or omission that is the basis for the claim of medical malpractice. MCL 600.5838a(1).

> At the time notice is given in compliance with the applicable notice period under section 2912b, if during that period a claim would be barred by the statute of limitations or repose; but in this case, the statute is tolled not longer than the number of days equal to the number of days remaining in the applicable notice period after the date notice is given.[7]

The practical effect of the tolling by the NOI is if there were 5 days left on the statute of limitations when the NOI was sent, the statute would be tolled the 182 days. After the 182 days expired, the 5 days would start to run again and the plaintiff would have 5 days to file the action. The filing of the action within these 5 days would again toll the statute of limitations and the case would be deemed timely filed. If there were 100 days remaining on the statute of limitations, when the NOI was sent, the same time would be available to file after the 182 waiting period on the NOI expired. The tolling provision for the filing of the case is within that same section as that for tolling using the NOI.

> The statutes of limitations or repose are tolled in any of the following circumstances: (a) At the time the complaint is filed, if a copy of the summons and complaint are served on the defendant within the time set forth in the supreme court rules.[8]

The tolling of the statute of limitations by filing of the case has been the traditional method of calculating the timely filing of a case. With the legislation of 1994, there are now two tolling sections that come into play with the filing of a medical malpractice case.[9]

It is the interactions of these two tolling periods and the strict pleading requirements of the NOI that has resulted in hundreds of meritorious cases being dismissed at the earliest stages of the case.

Problems created by the interaction of the two tolling statutes, the strict application of the NOI provisions without any means of correcting any alleged deficiency before the statute of limitations has expired.

- Unlike the filing of a complaint, there is no requirement that the defendant raise objections to what they may see as insufficient informations in the NOI, which would provide the patient an opportunity to amend the NOI, to provide the

[7] MCL 600.5856(c)
[8] MCL 600.5856(a)
[9] It should be noted that these 2 sections interact only when the NOI is sent within 6 months of the 2 year statute of limitations. Otherwise there is no tolling needed as the 182 day waiting period would expire before the 2 year statute of limitations and the case could be filed before the 2 year period. As a practical matter, because the 2 years is relatively short, most patients do not go to an attorney until some time after the negligent event (they will continue to treat with the health care provider for months after the negligent act) and getting records and evaluating the issues take considerable time, most NOI's are sent within the 6 months before the statute of limitations would run.

additional information.[10] Therefore, what does the defendant do if there is a perceived deficiency in the NOI – nothing. They wait until the statute of limitations has expired, and object that the NOI is deficient in some technical aspect. If the court agrees, the case is dismissed because a defective NOI does not toll the statute of limitations, which has now run.[11] This is mere procedural games that would not be permitted with the filing of a complaint in any other type of action. The normal practice is if, after the compliant is filed, the defendant wants a more specific statement of the claim, a motion is filed and the plaintiff is permitted to amend the complaint, which relates back to the original filing date.[12]

- The NOI has been interpreted to restrict all future claims of negligence if not specifically set forth in the NOI even if the claims arose out of the same care and treatment.[13] Thus, the NOI has effectively preempted the Michigan General Court Rules for medical malpractice claims. MCR provides for amendments to pleadings to allege new acts and theories of negligence uncovered during the discovery process. In fact, if there is no prejudice to the defendant, pleadings under MCR can be amended as late as the time of trial.[14]

- The NOI has been determined not to apply to savings provisions in the wrongful death statute, in the now infamous Waltz decision.[15] This effectively shortened the statute of limitations for family members filing a wrongful death to less than 18 months from the Probate Court issuing the family letters of authority, which they need to even get the records to investigate the care and treatment.

Amendments, which would effectuate the original intent of the 1994 legislation.

- That the defendant be required to raise any objections to deficiencies in the NOI 28 days after the NOI is sent, or such objections would be deemed waived. If objections were raised, the plaintiff would have 28 days to file an amended NOI, which would relate back to the date of the original NOI.

- That the Michigan General Court Rules would govern in any conflict between the NOI provisions and MCR, or the complaint could assert any theory or claim that arises out of the care and treatment as set forth in the NOI.

- That the tolling provisions of the NOI statute also apply to the savings provision statutes.

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[10] 2912b imposed no requirement on defendants to object to the sufficiency of plaintiff's notices of intent before the filing of the complaint. Roberts v Mecosta, 470 Mich 679, 681 (2004).

[11] After the waiting period required under MCL 600.2912b had passed, plaintiff filed her complaint. Thereafter, defendants filed motions for summary disposition. Defendants argued, inter alia, that plaintiff's claims were barred by the statute of limitations because the notices of intent failed to comply with the requirements outlined in MCL 600.2912b(4). Roberts, supra 685.

[12] MCR 2.118

[13] Gulley-Reaves v Baciewicz, M.D., 260 Mich App 478 (2004)

[14] MCR 2.118 (C)

[15] Waltz v Wyse, 469 Mich 642 (2004)

AFFIDAVIT OF MERIT

In an attempt to insure that medical malpractice cases had merit before filing, the 1994 legislation required that all cases filed be accompanied by an affidavit of merit (AOM) signed by a physician with similar qualifications as the defendant. Due to difficulties in determining the defendant's actual qualifications, areas of specialization at the time, and what the specialty certification was and by whom, cases reviewed by experts and filed with an AOM are dismissed. More disturbing is the fact that even where the expert meets all of the statutes demands, cases are being dismissed because of technical issues about the affidavit's form, particularly the notary's signature, and the authority of notaries in other states. Similar to the problems with the NOI, since the AOM is required to be filed with the complaint, if the AOM is later found defective, the complaint is not deemed to be properly filed, and if this is raised after the statute of limitations had expired, which it always is, the case is dismissed.

The pertinent part of the AOM statute is as follows:

> [T]he plaintiff in an action alleging medical malpractice... shall file with the complaint an affidavit of merit signed by a health professional who the plaintiff's attorney reasonably believes meets the requirements for an expert witness under section 2169.[16]

Although there are additional expert qualification requirements, those that are most often at issue are in the following section of 2169.

> If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.[17]

These sections become critical as the statute states the affidavit "shall" be filed with the complaint. As cited earlier, the primary method of tolling the statute of limitations period in a civil case is by filing the complaint.

> The statutes of limitations or repose are tolled in any of the following circumstances: (a) At the time the complaint is filed, if a copy of the

[16] MCL 600.2912d
[17] MCL 600.2169(1)(a)

summons and complaint are served on the defendant within the time set forth in the supreme court rules[18]

The conundrums that would quickly arise from the interplay of these sections, and the application of these terms in the complex practice of medicine, should be readily apparent. If the complaint is filed, does it need the affidavit of merit attached to toll the statute of limitations? There is no exception made in MCL 600.5856(a) stating that in a medical malpractice case the statute is tolled only if an AOM is attached, but that is exactly what our Supreme Court has held.[19] What if AOM is attached to the complaint when filed, but later determined to be deficient and the statue of limitations has expired? If the AOM is determined not to meet the minimal requirements of 2169, the case is dismissed. If the statute of limitations has expired, it is dismissed with prejudice.[20]

The above questions are simple in comparison to any attempt to determine what the proper expert may be to sign the AOM. What is a specialist? Is it the area in which one was trained? What if the defendant's residency training was in pediatrics, but at the time the physician was working in an ER and the patient is an adult? What if the defendant is board certified in pediatrics, practices 40% of the time in pediatrics, but works 60% of the time in an ER? Does one have to find the trained and practicing twin as an expert? That is what the defendants daily argue.

There is no definition of "specialist" in the statute, and rightfully so, as most specialists disagree on the definition. However, the law imposes this burden on the plaintiff, and if his interpretation differs from the trial judge, regardless of the merits of the case, the case is dismissed.

If one attempts to cover all bases, and gets a pediatrician and an ER expert, the cost of litigation effectively starts to eliminate valid claims from being filed. If one attempts to find a matching expert (60% pediatrics and 40% ER, with board certification in pediatrics) the process quickly becomes absurd and fruitless.

To add to all the above confusion is the question of what board certification means and as defined by whom. One of the pitfalls of legislation is to use a term that is defined by others, and where even they disagree on the definition. The ABMS (American Board of Medical Specialties) has a four-volume publication, in size 6-font print, listing all the physicians in the US, which have been certified by their member bodies. They list 24 general boards of certification. There are over one hundred subspecialty areas that they call "special certificates". However, in practice, many physicians list on their CV's the special certificate as a board certification.

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[18] MCL 600.5856(a)

[19] Scarsella v Pollak, 461 Mich. 547 (2000)

[20] Geralds v Munson Healthcare, 259 Mich App 225, 239-240; 673 NW2d 792 (2003); Mouradian v Goldberg, 256 Mich App 566, 571-575; 664 NW2d 805 (2003).

To add to the confusion is the fact that the American Osteopathic Association, which certifies osteopathic surgeons, has 18 general board certifications and a long list of special certificates. The problem is the names the AOA attaches to their board certifications differ substantially from the ABMS. Thus, two physicians, an MD and a DO, could be practicing side by side, in the same hospital, in the same department, practicing the same specialty, but could not offer an opinion as to the care of the other as they did not have matching certifications.

This problem is so confusing, the Michigan Supreme has granted leave on all these issues, and invited the ABMS and the AOA to file amicus briefs, presumably so the medical profession can tell the court what the legislature meant when the latter used these terms. The confusion is apparent from the court's attempt to state the issues in a concise fashion.

> The parties are directed to include among the issues to be briefed: (1) what are the appropriate definitions of the terms "specialty" and "board certified" as used in M.C.L. § 600.2169(1)(a); (2) whether either "specialty" or "board certified" includes subspecialties or certificates of special qualifications; (3) whether M.C.L. § 600.2169(1)(b) requires an expert witness to practice or teach the same subspecialty as the [473 Mich. 857] defendant; (4) whether M.C.L. § 600.2169 requires an expert witness to match all specialties, subspecialties, and certificates of special qualifications that a defendant may possess, or whether the expert witness need only match those that are relevant to the alleged act of malpractice. See Tate v. Detroit Receiving Hosp., 249 Mich App 212, 642 N.W.2d 346 (2002); and (5) what are the relevant specialties, subspecialties, and certificates of special qualifications in this case.
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> The American Osteopathic Association's Bureau of Osteopathic Specialists, the Accreditation Council for Graduate Medical Education, and the Council of Medical Specialty Societies are invited to file briefs amicus curiae. Other persons or groups interested in the determination of the issues presented in this case may move the Court for permission to file briefs amicus curiae.[21]

The confusion goes on; there are more certification bodies. Some of these are legitimate, although fringe organizations. It is suspected others are being set up just to provide a technical shield for doctors who are concerned with litigation. This cottage industry is best described by Dr. Stephen Barrett, who has a web site to combat the unscrupulous.

> In 1995, Medical Economics Magazine reported that more than 75 boards not ABMS or AOA affiliated had issued certificates to thousands of

[21] Woodard v Custer, 473 Mich. 856 (2005)

> physicians. Although a few of these self-designated boards are run legitimately and may eventually achieve ABMS or AOA recognition, most do not require residency training in their specialty. The author stated that "some physicians use fringe board certification to attract patients, who usually don't know the difference.[22]

This problem of who is certifying whom and what was recognized by Justice Weaver in the above Supreme Court opinion granting leave to hear these issues.

> I write separately to note that whether "specialty" or "board certified" in M.C.L. §600.2169(1)(a) refers to subspecialties or certificates of special qualification is debatable. (FN1) It is possible that "board certified" refers only to the twenty-four board specialties recognized by the American Board of Medical Specialties (ABMS) and the eighteen board specialties recognized by the American Osteopathic Association (AOA). (FN2) But it has also been suggested that "board certified" refers to the more than one hundred subspecialties recognized and certified by the ABMS [473 Mich. 858] and the AOA. (FN3) The ABMS website further acknowledges that there are over 180 non-ABMS, "self-designated" medical "boards" in the United States, and the statute itself provides no language excluding any medical board from relevance. (FN4)[23]

With all due respect, tying the AOM to the complaint, when no one has a clue how to determine who is a qualified expert is not only a mess, it is an embarrassment. It is expected that the court will attempt to re-write the statute to lend some sense of order to this process, but it takes a large pill of optimism for anyone to think that will cure this dysfunctional statute.

Even if the AOM is attached to the complaint, which is timely filed, and the expert is deemed qualified, now the question has become: was the notary qualified, and did she/he do their job properly. Using a post civil war statute, the Court of Appeals has concluded that an AOM signed outside Michigan, needs not only a notarization, but also a certification by the clerk of the court in the county where the AOM was signed, stating that the notary was authorized to act.[24] This put the vast majority of medical malpractice cases on track for dismissal. On a motion for re-hearing, the Court of Appeals decision was applied prospectively only. The case is now waiting for the Supreme Court's decision on an application for leave.

While Apsey is on appeal, this decision has resulted in challenges to those AOM's properly notarized based on the fact that the certification in the state was not by the clerk of the court in the county where the AOM was signed, but by the Secretary of State for the particular state. This is based on the now favored textualist interpretation of statutes (versus common sense) and, if the statute says clerk of the

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[22] http://www.quackwatch.org/04ConsumerEducation/QA/board.html

[23] Woodard, supra.

[24] Apsey v. Memorial Hosp., 266 Mich App, 666702 N.W.2d 870 (2005)

court, the secretary of state does not satisfy Michigan law, even if that is the only certification available. This is a problem as more than 1/3 of the states do not certify notary's signatures with the clerk of the court, but only with the Secretary of State. It also creates a logistical hassle; most states seldom certify a notary's signature. The classic response of a clerk to an attorney's request for certification was, "What country are you calling from?"

What are the problems with the Michigan AOM?

- All the problems are the result of the Supreme Court's decision requiring the AOM be attached to the complaint in order that the filing of the complaint tolls the statute of limitations.

- It is only logical that the defense would spend inordinate time and money challenging the AOM since if they prevail, and the statute of limitations has run, as it always has before the challenge is made, the case is automatically dismissed.

- The AOM is a literal and figurative minefield of compliance problems. Not even the medical profession can agree on what constitutes a specialist in all but the obvious cases. Certification, 10 years after the statute was passed, is so confusing, the Supreme Court needs amicus briefs from the medical profession.

- Now the AOM can be thrown out if the person notarizing the AOM does not have their signature and authority authenticated. And, when the authenticator (certification) of the first authenticator (notary) does not comply with Michigan's 19th century statutes, then another round of challenges commences.

The above epitomizes the warning of Philip Howard, "The more precise the rule, the less sensible the law seems to be."

What are the solutions?

- Maintain the AOM requirement, but disconnect it from the statute of limitations. Alternatively, only require the filing of the complaint to toll the statute. If the affidavit were not produced with the complaint, the court could deal with the individual situation as they do with the failure to make other discovery requests.

- Like other statutes using terms of art, define specialist and certification, and is an identical match required regardless of the care involved, or is it the area of specialization at the time of the malpractice.

- Eliminate the need to have signatures on AOM notarized, or at least that the notaries of other states be accepted as if they were notarized in Michigan.

PROXIMATE CAUSE BURDEN OF PROOF

Proximate cause proofs have been rendered impossible in many cases by an over read of the 1994 changes to MCL 600.2912a(2). The interpretation now being applied has been expanded far beyond the perceived problem originally intended to be corrected, thereby depriving Michigan citizens of recourse for negligent treatment.

An issue in 1993 was the Supreme Court decision of Falcon v Memorial Hospital, 436 Mich 443 (1990). The question was whether a patient could satisfy their burden of proximate cause proofs where the original chance for recovery, at the time of the negligence, was less than the traditional 51%, but where the lost chance was considered to be "a substantial loss of opportunity". The court in Falcon decided that a lost chance of 37.5%, when the negligence occurred, was substantial and sufficient. This decision was followed by further attempts to define substantial. In Weymers v Khera, 210 Mich App 231 (1995) the plaintiff lost a 30-40% chance to save her kidney. In Blair v Hutzel Hospital, 217 Mich App 502, 512 (1996) the plaintiff mother was deprived of a 25-30% chance that testing would have informed her that she was pregnant with a Downs infant which she could then decide whether she wanted to carry to term. The language the court uses on each occasion is, "deprived of a substantial opportunity".

The legislature, concerned that the burden of proving proximate cause was slipping lower and lower, sought to re-establish the 51% or greater test, which had been the test since the inception of tort law in Michigan.[25]

> In an action alleging medical malpractice, the plaintiff has the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants. In an action alleging medical malpractice, the plaintiff cannot recover for loss of an opportunity to survive or an opportunity to achieve a better result unless the opportunity was greater than 50%.[26]

Although the langauge and meaning had been clear to those practicing in the area for 6 years after the statute became effective, it apparently confused a Court of Appeals panel

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[25] This concept is best illustrated in the scales of justice statute. If the chance of avoiding the injury or death were greater than 51% at the time the diagnosis should have been made, but because of the negligence the scale tipped to the lower side, 50% or less, that satisfied the burden. The plaintiff had gone from "more probable than not" of no injury or survival, to "more probable than not" that injury or death would occur. Or, the scales of justice, the scales had tipped from above the horizontal to below.

[26] MCL 600.2912a(2), Amended by P.A.1993, No. 78, § 1, Eff. April 1, 1994.

in 2002, or perhaps not. From the comments in the courts decision, it was not clear. This appears to be another example of too precise regulation leading to less sensible results.

> In examining the second sentence of M.C.L. § 600.2912a(2), it is not clear to what the Legislature [253 Mich App 80] was referring when it stated that "the opportunity" must be greater than fifty percent. "[T]he opportunity" could either refer to the plaintiff's initial opportunity to survive or achieve a better result before the alleged malpractice or could refer to the plaintiff's loss of opportunity to survive or achieve a better result.[27] (Emphasis added).

Nevertheless, this panel went on to give their interpretation of what the legislature meant. What they decided is that the statute intended to correct far more than the Falcon concerns. The Fulton court opined that the change in the avoiding injury, from the date of the original negligence to the date the correct diagnoses was made, had to be greater than 51%. When given practical application, this meant if a woman's doctor failed to diagnose her breast cancer when the chances of survival were 60%, but did see the error of his ways and diagnoses the cancer when the chances of living were 10% (near certain death with cancer) the patient has no claim. The change must be 51% or greater. The outrage over this interpretation came not only from the legal profession, but made the nightly news.

MCL 600.2912a(2) should be amended to correct the Falcon concerns, and to clarify that Michigan will use the traditional burden of proof on proximate cause.

THE LAWSUIT TAX AND CAPS ON DAMAGES

While it may not be time efficient for the House Committee on Tort Reform to address all information disseminated to promote more pro-insurance legislation, there are assertions that need exposure, one being the lawsuit tax. Like most marketing concepts, this one certainly has all the key words to make it sound believable: "lawsuit and tax." However, it is a marketing slogan to sell a product and not a concept that any credible economist would support.

This slogan was originally asserted based on a study commissioned and paid for by ATRA (American Tort Reform Association). The accounting firm, Tillinghast Towers Perrin, basically added up all the money paid in lawsuits and divided by the number of US citizens. Much of the underlying data is inaccurate, but more misleading is the concept itself. It suggests that but for lawsuits, the payment of medical bills, lost wages, etc., incurred as the result of another person's negligence would otherwise never be part of the economy. In other words, these are not added expenses due to negligence and injury, but due to the lawsuits.

The Economic Policy Institute, a nonpartisan economic think tank in Washington DC, released their analysis of the Tillinghast numbers in May 2005. They found lawsuits

[27] Fulton v Pontiac General Hospital, 253 Mich App 70 (2002)

have not adversely affected employment, research and development, wages, or health care costs. The study concludes, "Any work that relies on these seriously flawed reports, is to that extent, also unreliable....the economic case made by critics for changing the US tort law system can only be called frivolous."[28]

The EPI notes the misleading statement in the study – that the cost of medical payments is a tax on the public. To the contrary, the EPI explains,

> Half of the "costs" that Tillinghast-Towers Perrin attributes to the tort system are not costs in any real economic sense. They are transfer payments from wrongdoers to victims. As the Congressional Budget Office points out, costs that "merely shift money from injurers to victims...are not true costs to society as a whole." (CBO 2003, 19).[29]

Transfer payments are a concept some would like to ignore. The real tax on the citizens of this state would be if we had to pay for the cost of negligently necessitated medical care through higher premiums, medicare and medicaid. If the negligent party were not required to make these payments, citizens would be taxed to subsidize second rate products and services.

This mantra has no more substance than the often repeated, "caps prevent frivolous lawsuits." This focused grouped mantra also has a certain ring to it, but it makes no sense. Only the meritorious cases with substantial damages are capped. Frivolous cases, or those without merit, are worth nothing – these never reach the caps. It is the seriously injured, with lifelong, permanent injuries, that are twice wronged when the judge, after the verdict, and unknown to the jury, reduces the award. It defies logic to state that caps on damages, applied after the verdict, and only to cases that are found meritorious and with significant injuries, prevent the filing of cases without merit.

Fair and meaningful legislation will only result if based on facts, not slogans.

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[28] http://www.epinet.org/content.cfm/bp157

[29] It is noteworthy that the CBO (Congressional Budget Office) in 2003 came to the same conclusion. The only study that came to an opposite opinion is those hired and paid for by ATRA.